TREATING PHYSICIAN'S REPORT OF DISABILITY STATUS

INSTRUCTIONS: Pursuant to requirements of the California Labor Code, please complete this form and return it to the claim administrator listed below within 15 days of receipt with a copy to the Qualified Rehabilitation Representative.

EMPLOYEE NAME: (LAST) (FIRST) (M.I.)	SS#	DATE OF INJURY

EMPLOYER NAME:

Attached is a description of the employee's job duties. Based on your examination, including the history provided by the patient and the enclosed job description, choose one of the following:

____ I expect to release the employee to return to the pre-injury occupation on or about _____.

____ The employee's permanent disability as a result of the injury whether or not combined with the effects of a prior injury or disability, if any, is likely to preclude the employee from returning to work at the pre-injury occupation.

Is the employee currently physically able to participate in vocational rehabilitation services? ___ Yes ___ No

If yes, please describe any physical limitations:. _____

_____

If employee is not physically able to participate in vocational services, please estimate when participation may be possible:

_____

_____ At this time, I am unable to give an opinion concerning the employee's ability to return to the pre-injury occupation. I expect to be able to provide an opinion on or about: _____ .

Please advise also if the employee is currently physically able to perform light duties if modified or alternative work is available:

_____ Yes, with the following limitations: _____

_____

_____ No

Physician's Name _____ Date: _____

Physician's Signature _____

Please return to: Employer/Insurer/Adjusting Agent Claim #:

Address: (Street) (City) (State) (Zip)

Send a copy to Qualified Rehabilitation Representative:

Address (Street) (City) (State) (Zip)

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STATE OF CALIFORNIA
DWC FORM RU-90 (12/90)